SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: 2010 Dental and Vision Policy	SERFF Tr Num: RNIC-126687030	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 46020
Sub-TOI: H10I.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Authors: Kyle Conrad, Brenda Ingram, Misty Anglin	Disposition Date: 06/29/2010
	Date Submitted: 06/22/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: 2010 Dental and Vision Policy
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/29/2010

Deemer Date:
Submitted By: Brenda Ingram
Filing Description:
Ms. Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 06/29/2010
Created By: Brenda Ingram
Corresponding Filing Tracking Number:

RE: Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Form DV-1 – Dental and Vision Expense Policy
Form OC DV-1 (7/10) – Outline of Coverage
Form UAP-1 AR (7/10) – General A&H Application
Form RP-A&H – Notice to Applicant Regarding Replacement
Form DV-Med. Notice – Important Notice to Persons on Medicare

Dear Ms. Minor:

We are submitting the above-referenced forms, which we request you consider for approval. This is a new filing not previously submitted.

Form DV-1 is an individual guaranteed renewable policy that pays limited benefits for certain stated dental and vision services on a policy year basis. We anticipate that Form DV-1 will be available to individuals age 0 through 85.

The following forms to be used with Form DV-1 are also included with this submission:

1. Form OC DV-1 (7/10) – Outline of Coverage, which will be used in connection with each application for Form DV-1.

2. Form UAP-1 AR (7/10) – General A&H Application, which will be used as the application for Form DV-1. This application will also be used with our other applicable A&H policies that were previously approved by your office. It will not be used for Medicare supplement policies.

3. Form RP-A&H – Notice to Applicant Regarding Replacement, which will be used in replacement situations. This form was previously approved by your office.

4. Form DV-Med. Notice – Important Notice to Persons on Medicare, which will be furnished to each applicant who is eligible for Medicare at the time of application.

We are also submitting the applicable rates and a supporting actuarial memorandum.

If this filing meets with your approval, please furnish us evidence thereof.

Thank you for your consideration in this matter. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

Sincerely,

Kyle D. Conrad

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Senior Vice President
and Associate Corporate Counsel

Company and Contact

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel	kconrad@unitrin.com
6100 N. W. Grand Blvd	800-874-1431 [Phone] 549 [Ext]
Oklahoma City, OK 73118	

Filing Company Information

Reserve National Insurance Company	CoCode: 68462	State of Domicile: Oklahoma
6100 N.W. Grand Boulevard	Group Code: 215	Company Type: Life and Health
Oklahoma City, OK 73118	Group Name: Reserve National	State ID Number:
(405) 848-7931 ext. 549[Phone]	FEIN Number: 73-0661453	

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	Yes
Fee Explanation:	Policy and 3 forms @ 50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	$200.00	06/22/2010	37407516

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/29/2010	06/29/2010

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Disposition

Disposition Date: 06/29/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Form RP-A&H	Approved-Closed	Yes
Form	Dental and Vision Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	General A&H Application	Approved-Closed	Yes
Form	Important Notice to Persons on Medicare	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
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Form Schedule

Lead Form Number: DV-1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/29/2010	DV-1	Policy/Contract/Fraternal Certificate	Dental and Vision Policy	Initial		88.392	DV_POLICY_AR.pdf
Approved-Closed 06/29/2010	OC DV-1 (7/10)	Outline of Coverage	Outline of Coverage	Initial			OC DV-1 7-10.pdf
Approved-Closed 06/29/2010	UAP-1 AR (7/10)	Application/Enrollment Form	General A&H Application	Initial			UAP-1 AR 7 10.pdf
Approved-Closed 06/29/2010	DV-Med. Notice	Other	Important Notice to Persons on Medicare	Initial			DV-Med. Notice.pdf

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS POLICY PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES. FOR EACH COVERED PERSON, THERE IS A DEDUCTIBLE AND A LIMITATION ON THE AMOUNT OF BENEFITS PAYABLE FOR EACH COVERED SERVICE. PREMIUMS ARE BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.

Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

When we use "we," "us," "Company" or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean a Covered person as defined in this Policy and as named on the Insured Schedule.

SUPPLEMENTAL DENTAL AND VISION EXPENSE POLICY

INSURING AGREEMENT

Reserve National Insurance Company agrees to indemnify the Insured to the extent hereinafter provided for certain specified expenses, subject, however, to all the provisions, conditions, exclusions, limits of liability and other terms of this Policy.

In consideration of the payment of the premium in advance and in reliance upon the statements in the application of the Insured, a copy of which is attached and which forms a part of this Policy, the Company hereby insures those persons named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where the Insured resides, on the Effective Date shown on the Insured Schedule. Upon the expiration of the initial term, as shown on the Insured Schedule, this Policy, subject to the Renewability provision, may be continued in effect by the payment in advance, or within the grace period specified herein, of the premium in effect at the time of such renewal.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

TEN DAY RIGHT TO EXAMINE POLICY

You are granted a period of ten days from the date of delivery of this Policy to examine it, and if not satisfied for any reason, this Policy may be returned within said ten days to the Company at its Home Office or to the writing agent. Then the Company shall refund the premium paid, and this Policy shall be void from its beginning, and you and Reserve National shall be in the same position as if it had never been issued.

THIS IS A LIMITED BENEFIT POLICY. IT PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES. IT DOES NOT COVER HOSPITAL EXPENSES.

THIS POLICY IS GUARANTEED RENEWABLE AT YOUR OPTION.

READ THIS POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE.

TABLE OF CONTENTS

INSURED SCHEDULE

	Renewal Premium:	Direct Bill	Bank Draft
Policy Number	Monthly		
Effective Date	Quarterly		
Initial Term Expires	Semi Annual		
Initial Premium	Annual		
Insured	Agent		

Dependents

Policy Benefits and Limitations

For each Covered Person in each Policy year: After the Deductible is satisfied, benefits payable for stated dental and vision expenses are the applicable Benefit Percentage of the Expense Incurred, subject to the Maximum Policy Year Aggregate Benefit and the limitations shown below and reflected in the provisions of this Policy.

There are specific limits on the amount of benefits payable for Type 1 Dental Services (routine check-ups), Type 2 Dental Services, Eye Examinations, and Lenses and Frames. Please refer to the provisions on the noted page numbers for details.

Deductible (must be satisfied by each Covered Person in each Policy Year) [page 3]…….$100.00

Benefit Percentage [page 4]

Dental Benefit [page 4]:

Type 1 Dental Services [page 4] 80%

Type 2 Dental Services [page 4] 60%

Vision Benefit [page 4]:

Examination [page 4].....80%

Lenses and Frames [page 4].....80%

Maximum Policy Year Aggregate Benefit [page 4]..... $1,000.00 per Policy Year

Endorsements

- Endorsements continued on reverse side -

INSURED SCHEDULE

Endorsements and Eliminations (Continued)

DEFINITIONS

The following terms in this Policy are defined as follows:

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid. Upon the insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death.

PHYSICIAN: "Physician" means any person (other than a relative of a Covered Person) who is a legally qualified and licensed practitioner, practicing within the scope of his or her authority and license, including a dentist, ophthalmologist or optometrist.

DEDUCTIBLE: "Deductible" means the amount of covered dental or vision expenses that must be incurred in each Policy Year before any benefits are payable in a Policy Year. No benefits are payable for covered expenses making up the Deductible. Each Covered Person must satisfy the Deductible each Policy Year while this Policy is in force before benefits are payable to that Covered Person in a Policy Year. The Deductible under this Policy is shown on the Insured Schedule.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the 12-month period immediately preceding the Effective Date of this Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the 12-month period following the Effective Date of this Policy.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy so that each successive 12-month period constitutes a single Policy Year.

BENEFIT PERCENTAGE: "Benefit Percentage" means the percentage of covered Expenses Incurred for dental or vision services or items for which benefits are payable under this Policy. The Benefit Percentage under this Policy is shown on the Insured Schedule.

EXPENSE INCURRED: "Expense Incurred" means the charges actually incurred by a Covered Person for covered dental and vision services or items that are prescribed by a Physician. Expense is considered incurred on the date treatment is provided.

DENTAL AND VISION EXPENSE BENEFITS

If a Covered Person, while this Policy is in force, incurs any of the following covered expenses in a Policy Year, we will pay benefits as follows:

(a) First, the **Deductible** shown on the Insured Schedule must be satisfied for each Policy Year. No benefits are payable for any covered expense making up the Deductible.

(b) Then, we will pay the **applicable Benefit Percentage**, as shown on the Insured Schedule, of the following items, **limited to the Maximum Policy Year Aggregate Benefit** shown on the Insured Schedule:

(1) **Dental Benefit:**

(A) **Type 1 Dental Services:** A routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis (cleaning), **limited to a maximum benefit of $100.00 for each dental check-up and further limited to two dental check-ups in each Policy Year**.

(B) **Type 2 Dental Services:** Services of a licensed dentist other than Type 1 Dental Services, including fillings, root canals, crowns, bridges, onlays and dentures. Replacement or repair of existing fillings, crowns, bridges or dentures will not be covered until after this Policy has been in effect for 12 months or more.

The Dental Benefit does not include (i) oral hygiene supplies; (ii) cosmetic dental care or treatment, such as bonding or teeth whitening, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; (iii) orthodontic treatment or dental implants, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; or (iv) diagnosis or treatment of temporomandibular joint syndrome or craniomandibular joint syndrome.

(2) **Vision Benefit:**

(A) **Eye Examination:** An eye examination for the purpose of refraction, including any required diagnostic vision services in conjunction with the examination, performed by a Physician, including an ophthalmologist or optometrist, **limited to a maximum benefit of $100.00 for each eye examination and further limited to one eye examination in each Policy Year**.

(B) **Lenses and Frames:** Eyeglass lenses (and frames) or contact lenses, excluding sunglasses, **limited to an aggregate benefit of $300.00 in any 24-month period**. Replacement of existing eyeglasses or contact lenses will not be covered until this Policy has been in effect for 12 months or more.

EXCLUSIONS

This Policy does not cover any loss caused or contributed to by: (a) war or any act of war (whether war is declared or not); (b) any intentionally self-inflicted injury; (c) drug abuse or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) participation in a felony or attempted felony, riot or insurrection; (f) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (g) treatment received in a United States Government or Veterans facility for which a Covered Person is not required to pay; (h) cosmetic dental care or treatment, **except** that treatment of accidental injury received that occurred while this Policy is in force will be covered subject to the provisions of this Policy; (i) surgery to correct myopia, hyperopia, presbyopia or astigmatism: (j) procedures performed by you or a member of your immediate family ("immediate family" means your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence); (k) prescription drugs; (l) expenses incurred to the extent benefits therefor are actually paid by Medicare.

PRE-EXISTING CONDITIONS LIMITATIONS

Pre-Existing Conditions are not covered under this Policy until this Policy has been in force for a period of 12 months; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under this Policy by name or specific description on the date of the loss.

TERMINATION

Subject to the Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Coverage for Spouse and Dependent Children provision.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are unmarried and under 19 years of age and who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

The coverage on any child will terminate on the anniversary date of this Policy after the child's 19th birthday, or the child's marriage, whichever occurs first. Termination of coverage shall be without prejudice to any claim originating prior thereto. Our acceptance of premium after such date shall be for the remaining persons who qualify for coverage under this Policy; provided that coverage shall continue for any Covered Person during the period for which we accept an identifiable premium for such Covered Person. Coverage may be continued for any covered dependent child regardless of age who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 19. Proof of such incapacity and dependency must be furnished to us by you at our request and expense.

If the coverage of a child terminates under this provision due to his/her attaining age 19 or marriage, such child shall be eligible to have issued to him/her without evidence of insurability a policy with benefit and renewability provisions the same as or similar to this Policy that the Company is then issuing.

CONTINUATION OF COVERAGE UPON DIVORCE

If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under the Policy.

RENEWABILITY

Subject to the limitations stated in the Termination provision, this Policy is **guaranteed renewable** at your option. We reserve the right to change the premiums for this Policy in accordance with the Premium Payments provision.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to the Company at its Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as hereinafter provided in the Grace Period provision.

(b) Premiums may be changed. Premiums for this Policy are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to an Insured's sex, attained age, smoking status and/or state (or other geographic classification) of residence. We will give you 31 days notice before any such premium change.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the Policy shall be valid until approved in writing by a Vice President, the Secretary or the President of the Company, and signed at our Home Office. Such approval must be noted on or attached to this Policy. No agent may change this Policy, and no agent may waive any of its provisions.

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After two years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person under this Policy, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for loss incurred commencing after expiration of such two years.

(b) We shall not deny or reduce a claim for loss incurred after 12 months from the Effective Date of coverage of this Policy on the ground that a disease or physical condition on the date of loss had existed before the Effective Date of coverage of this Policy.

3. GRACE PERIOD: There will be a grace period of 31 days for payment of each premium falling due after the first premium. This Policy will stay in force during the grace period.

4. REINSTATEMENT: This Policy will lapse if you do not pay the premium before the end of the grace period. If the Company or any agent authorized by the Company to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. Without such approval, this Policy will be reinstated on the 45th day of such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy will cover only loss due to an Injury occurring after the date of reinstatement or a Sickness beginning more than 10 days from such date. In all other respects you and the Company will have the same rights under this Policy as were in effect before it lapsed, unless special conditions or provisions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and policy number. Notice should be mailed to us at our home office or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will send you forms for filing proof of loss. If we do not send them within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. This statement should include the type of and extent of the loss you incurred. We must receive this statement within the time given for filing proof of loss.

7. PROOF OF LOSS: You must give us written proof of your loss within 90 days after the date of loss or as soon as you reasonably can. Proof must, however, be furnished within 12 months except in the absence of legal capacity.

8. TIME OF PAYMENT OF CLAIMS: We will pay you immediately upon receipt of due written proof of loss for benefits provided under this Policy. However, a benefit that is payable by periodic payments, subject to due written proof of loss, shall be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

UNIFORM PROVISIONS (Continued)

9. PAYMENT OF CLAIMS: (a) Subject to the Direct Payment of Dental or Vision Services provision, benefits will be paid to the Insured. Loss-of-life benefits, if any, are payable in accordance with the beneficiary designation in effect at the time of payment. If a beneficiary designation is not then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at the Company's option, either to your beneficiary or estate. (b) If benefits are payable to your estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $1,000.00 to someone related to the Insured or beneficiary by blood or marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

10. PHYSICAL EXAMINATION: We may have you examined by a Physician at our expense when and as often as we may reasonably require while a claim is pending.

11. LEGAL ACTIONS: No action at law or in equity may be brought to recover on this Policy within 60 days after written proof of such loss has been given as required by the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be given.

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this policy. Also, no such consent shall be required for surrender or assignment of this policy.

POLICY PROVISIONS

1. MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated, all benefits payable with respect to that Covered Person shall be in the amount the premium paid would have purchased at the correct age.

2. UNPAID PREMIUM: Any due and unpaid premium for this Policy may be deducted from its benefits then payable.

3. ILLEGAL OCCUPATION: We shall not be liable for any loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for a loss to which a contributing cause was your participation in an illegal job.

4. INTOXICANTS AND NARCOTICS: The Company shall not be liable for any loss sustained or contracted in consequence of a Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

5. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.

6. DIRECT PAYMENT OF DENTAL OR VISION SERVICES: Subject to any written direction of the Insured, all or any portion of any indemnities provided hereunder on account of dental or vision services may, at the Company's option, and unless the Insured requests otherwise, not later than the time of filing proofs of such loss, be paid directly to the person rendering such services.

7. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON: In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the Effective Date, and to be executed by its President and Secretary at its Home Office at 601 East Britton Road, in the City of Oklahoma City, Oklahoma.

Secretary

President

THE PHOTOCOPY OF THE APPLICATION ATTACHED HERETO CONSTITUTES PART OF THE CONTRACT

THIS SPACE INTENTIONALLY LEFT BLANK

Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

THIS IS A SUPPLEMENTAL DENTAL AND VISION EXPENSE POLICY

THIS POLICY PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES. FOR EACH COVERED PERSON, THERE IS A DEDUCTIBLE AND A LIMITATION ON THE AMOUNT OF BENEFITS PAYABLE. THIS POLICY DOES NOT COVER HOSPITAL EXPENSES.

Reserve National INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

SUPPLEMENTAL DENTAL AND VISION EXPENSE POLICY

THIS POLICY PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES

OUTLINE OF COVERAGE

Reserve National Insurance Company is hereinafter referred to as "we," "us" or "our." The individual(s) covered under the Policy are referred to as "you," "your" or "Covered Person."

NOTE: This policy is NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

1. READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of Dental and Vision Expense Policy Form DV-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

2. SUPPLEMENTAL DENTAL AND VISION EXPENSE COVERAGE is designed to supplement your existing coverage. Coverage is provided ONLY for certain dental and vision expenses as stated in the Policy, subject to all the Policy's conditions, limitations and exclusions. This policy does not cover hospital expenses. THIS IS A LIMITED BENEFIT POLICY. THIS POLICY IS DESIGNED TO SUPPLEMENT, NOT REPLACE, EXISTING HOSPITALIZATION AND MEDICAL COVERAGE.

3. DENTAL AND VISION EXPENSE BENEFITS: If you, while the Policy is in force, incur any of the following covered expenses in a Policy Year, we will pay benefits as follows:

(a) First, the **Deductible** you select below must be satisfied for each Policy Year. No benefits are payable for any covered expense making up the Deductible.

_____ (applicant's initials to select) $_____ **Deductible**

Each Covered Person must satisfy this Deductible before any benefits are payable to that Covered Person in that Policy Year.

(b) Then, we will pay the **applicable Benefit Percentage** (shown below) of the following items, **limited to the Maximum Policy Year Aggregate Benefit** you select below:

(1) **Dental Benefit:**

(A) **Type 1 Dental Services:** A routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis (cleaning), **limited to a maximum benefit of $100.00 for each dental check-up and further limited to two dental check-ups in each Policy Year**.

(B) **Type 2 Dental Services:** Services of a licensed dentist other than Type 1 Dental Services, including fillings, root canals, crowns, bridges, onlays and dentures. Replacement or repair of existing fillings, crowns, bridges or dentures will not be covered until after the Policy has been in effect for 12 months or more.

The Dental Benefit does not include (i) oral hygiene supplies; (ii) cosmetic dental care or treatment, such as bonding or teeth whitening, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; (iii) orthodontic treatment or dental implants, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; or (iv) diagnosis or treatment of temporomandibular joint syndrome or craniomandibular joint syndrome.

(2) **Vision Benefit:**

(A) **Eye Examination:** An eye examination for the purpose of refraction, including any required diagnostic vision services in conjunction with the examination, performed by a Physician, including an ophthalmologist or optometrist, **limited to a maximum benefit of $100.00 for each eye examination and further limited to one eye examination in each Policy Year**.

(B) **Lenses and Frames:** Eyeglass lenses (and frames) or contact lenses, excluding sunglasses, **limited to an aggregate benefit of $300.00 in any 24-month period**. Replacement of existing eyeglasses or contact lenses will not be covered until the Policy has been in effect for 12 months or more.

4. BENEFIT PERCENTAGE: For each covered service the applicable Benefit Percentage is as follows:

Dental Benefit:
Type 1 Dental Services..... **80%**
Type 2 Dental Services **60%**

Vision Benefit:
Examination **80%**
Lenses and Frames **80%**

5. MAXIMUM POLICY YEAR MAXIMUM BENEFIT: For each Covered Person, the benefits payable in any one Policy Year are limited to the **Maximum Policy Year Aggregate Benefit** you select below:

_____ (applicant's initials to select) $_____ **Maximum Policy Year Aggregate Benefit**

(Continued on reverse side)

6. EXCLUSIONS: The Policy does not cover any loss caused or contributed to by: (a) war or any act of war (whether war is declared or not); (b) any intentionally self-inflicted injury; (c) drug abuse or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) participation in a felony or attempted felony, riot or insurrection; (f) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (g) treatment received in a United States Government or Veterans facility for which a Covered Person is not required to pay; (h) cosmetic dental care or treatment, **except** that treatment of accidental injury received that occurred while this Policy is in force will be covered subject to the provisions of this Policy; (i) surgery to correct myopia, hyperopia, presbyopia or astigmatism: (j) procedures performed by you or a member of your immediate family ("immediate family" means your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence); (k) prescription drugs; (l) expenses incurred to the extent benefits therefor are actually paid by Medicare.

7. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of 12 months; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of loss. "Pre-existing condition" means a condition which has been diagnosed, or has manifested itself to you within the 12-month period immediately preceding the Effective Date of the Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the 12-month period following the Effective Date of the Policy.

8. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Policy's Coverage for Spouse and Dependent Children provision.

9. RENEWABILITY: Subject to the Policy's Termination provision, the Policy is **guaranteed renewable** at your option. We reserve the right to change premiums in accordance with the Policy's Premium Payments provision.

10. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to an Insured's sex, attained age, smoking status and/or state (or other geographic classification) of residence. We will give you 31 days notice before any such premium change.

THIS IS A LIMITED BENEFIT POLICY.

IT ONLY PROVIDES BENEFITS FOR STATED DENTAL AND VISION EXPENSES. THIS POLICY IS NOT DESIGNED TO COVER ALL EXPENSES ASSOCIATED WITH YOUR DENTAL AND VISION NEEDS.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

The undersigned applicant hereby acknowledges receipt of a copy of this Outline of Coverage.

Dated this _____ day of _____ , year_____. Signed at_____ ,

State of _____ .

_____ Agent's Signature

_____ Applicant's Signature

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.]
Dental and Vision Expense Policy Form DV-1 is individually underwritten by Reserve National Insurance Company.

Reserve National INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA
GENERAL A&H APPLICATION

AGENT CODE _____
MGR CODE _____

FOR HOME OFFICE USE ONLY

POLICY NUMBER(S):

EFFECTIVE DATE: Month | Day | Year

1. Full Name of Each Applicant

	First	Middle Initial	Last	Social Security No.	Relation To Proposed Insured	BIRTH DATE Mo.	Day	Yr.	Age	Ht.	Wt.	Sex
1					Proposed Insured							
2												
3												
4												

Check policy/policies applied for (availability of policies varies by state):

❑ Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1
❑ Limited Benefit Hospital and Surgical Expense Policy LHS
❑ Scheduled Benefit Accident-Only Policy SA-1

Benefit %	Deductible $	Daily Room Max. $	Hospital Misc. Max. $

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

❑ Supplemental First Diagnosis Heart Attack and First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) $_____
First Major Heart Surgery Benefit (after 30 days) $_____

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

Accident Policy
❑ AP-79 ❑ AP-02-79
❑ AP-91 ❑ AP-91-70

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Dental/Vision Expense Policy
Pol. Yr. Ded. $_____
Pol. Yr. Max. $_____

App't #	Total Monthly Prem.
1	
2	
3	
4	

Supplemental Outpatient Expense Policy Deductible $_____
❑ OS-99 ❑ OP-2000

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

❑ Hospital Indemnity Policy HDI ❑ Fixed Indemnity Policy SIP-1*
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

***Elimination Period Before Daily Indemnity is Payable: _____ Days**

Total _____

❑ Home Health Care
Indemnity Policy HHC-95

App't #	Basic Mthly. Rt.	List Endorsements & Rates				Total Monthly Premium
1						
2						
3						
4						

Total _____

Cancer Policy
❑ CFO-95-First Occurrence Cancer Benefit After 180 Days $_____
❑ CC-74 ❑ CC-91

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death $_____

App't #	Total Monthly Prem.	PEB Table
1		

Total _____

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
Street No. / Rural Route and/or Box Number City State Zip Code

3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____

3.(a) E-mail address _____ **3.**(b) Name, Address and Telephone No. of payor, if different from above _____

_____

3.(c) Each Applicant's State of Birth _____

4.(a) Proposed Insured's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____

5. Full Name of Beneficiary(ies) and Relationship _____

Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.

6. If submitted for purposes other than a new insurance application, please indicate: ❒ Policy Change ❒ Conversion ❒ Reinstatement: Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

_____

7. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

_____

8. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application for insurance? ❒ **Yes** ❒ **No** If yes, which applicant(s), company and amount? _____

_____ (Complete replacement of insurance form.)

9. Has any applicant used any form of tobacco within the past year? ❒ **Yes** ❒ **No** Within the past 3 years? ❒ **Yes** ❒ **No** If either are yes, which applicant(s)? _____

10. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly scheduled airline? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

_____

11. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing, scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or semi-professional athletics? ❒ **Yes** ❒ **No** Which applicant(s) and details? _____

_____

12. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? ❒ **Yes** ❒ **No** Which applicant(s) and details? _____

13. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not renewed? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

14. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

15. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

16. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or appliance? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

17. Is any applicant using any medication or drugs? ❒ **Yes** ❒ **No** If yes, which applicant(s) and name of medication? _____

_____

_____

18. Does any applicant currently have a dental crown or bridge, or wear dentures? ❒ **Yes** ❒ **No** If yes, which applicant(s) _____

19. Has any applicant been advised to have any dental work which has not been completed? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details. _____

20. Does any applicant currently wear eyeglasses or contact lenses? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details _____

_____

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

21. Disorder of eyes, ears, nose, throat or glands?.... ❒ **Yes** ❒ **No**
22. Dizzy or fainting spells, seizures or convulsions or recurrent headache? ..... ❒ **Yes** ❒ **No**
23. Paralysis, transient ischemic attack, stroke, cerebrovascular disease or insufficiency or hemorrhage, or any residuals thereof?..... ❒ **Yes** ❒ **No**
24. Mental, nervous, psychiatric disorder ..... ❒ **Yes** ❒ **No**
25. Senility disorder, Alzheimer's disease, organic brain syndrome or disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease, neurologic or muscular wasting disease? ..... ❒ **Yes** ❒ **No**
26. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, allergies, emphysema, tuberculosis, pneumonia or other

(Continued at top of next page)

lung or respiratory disorder(s)?.....❒ **Yes** ❒ **No**

27. Chest pain, discomfort or tightness, any heartbeat abnormality, abnormal EKG, rheumatic fever, heart murmur, heart attack or other disorder of the heart? ..... ❒ **Yes** ❒ **No**

28. Hypertension, high blood pressure, high cholesterol, carotid artery disease, coronary artery disorder, blood clot(s) or any other disorder of blood vessels?..... ..... ❒ **Yes** ❒ **No**

29. Has any applicant been advised by a physician or other practitioner to have any form of heart surgery, coronary artery surgery, arteriogram, angioplasty or pacemaker? ..... ❒ **Yes** ❒ **No**

30. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, esophageal reflux, or other disorder of the stomach, intestines, liver, hepatitis type B or C, gall bladder, pancreas or hemorrhoids? ..... ❒ **Yes** ❒ **No**

31. Sugar or blood in urine, end stage renal failure, stone or other disorder of kidney, bladder, prostate or reproductive organs? ..... ❒ **Yes** ❒ **No**

32. Diabetes or high blood sugar? ..... ❒ **Yes** ❒ **No**

If yes, which applicant(s) and age of onset? _____

_____

33. Thyroid or other endocrine disorders? ..... ❒ **Yes** ❒ **No**

34. Neuritis, sciatica, rheumatism, arthritis, gout, osteoporosis, or disorder of the muscles, ligaments, bones or joints, spine, back or disk disorder? ..... ❒ **Yes** ❒ **No**

35. Deformity, lameness, amputation or disabling injury? ..... ❒ **Yes** ❒ **No**

36. Disorder of the skin? ..... ❒ **Yes** ❒ **No**

37. Disorder of the lymph glands, unexplained fevers, cyst, tumor, cancer (including leukemia, Hodgkin's disease or lymphoma) or malignant neoplasm? ..... ❒ **Yes** ❒ **No**

38. Anemia, polycythemia vera, thrombocytopenia or other disorder of the blood? ..... ❒ **Yes** ❒ **No**

39. Have you or any applicant ever been diagnosed as having or been treated for AIDS, ARC (AIDS Related Complex), an immune deficiency disorder, HIV or any test results indicating exposure to the AIDS virus? ..... ❒ **Yes** ❒ **No**

40. Any sexually transmitted disease including syphilis, gonorrhea herpes, chlamydia or condyloma acuminata (anal or genital warts)? ..... ❒ **Yes** ❒ **No**

41. Has any applicant sought or received advice or treatment for use of alcohol or drugs? ..... ❒ **Yes** ❒ **No**

42. Has any female ever had any disorder or complications of menstruation, pregnancy, childbirth, the female organs or breasts? ..... ❒ **Yes** ❒ **No**

43. Is any applicant now pregnant? ..... ❒ **Yes** ❒ **No**

44. Other than above, in the last 5 years, has any applicant been examined, advised or treated by any physician or practitioner? ..... ❒ **Yes** ❒ **No**

45. In the last 5 years, has any applicant been a patient in a hospital, clinic, psychiatric clinic or other medical facility? ..... ❒ **Yes** ❒ **No**

46. Has any applicant ever had an EKG, X-ray, CT scan, MRI or other test? ..... ❒ **Yes** ❒ **No**

47. Has any applicant lost or gained weight in the past 12 months? ..... ❒ **Yes** ❒ **No**

If yes, state amount and cause of loss or gain and indicate which applicant(s)_____

_____

48. Has any applicant been advised not to donate or been refused to donate blood? ..... ❒ **Yes** ❒ **No**

If yes, which applicant(s) and explain why and by whom below.

49. Has any applicant ever had or been advised by a physician or other practitioner to have any type of organ transplant? .. ❒ **Yes** ❒ **No**

50. Other than above, in the last 5 years, has any applicant had any mental or physical disorder, checkup, consultation, illness, injury, surgery, been a patient in a hospital, clinic, sanatorium or other similar facility or been advised to have any hospitalization, surgery, biopsy, testing or treatment which was not completed, or had any departures from good health not mentioned above? ..... ❒ **Yes** ❒ **No**

If yes, give full details in Question #51below.

51. EXPLAIN YES ANSWERS TO QUESTIONS 18-50. (Attach additional page(s) if needed.)

Applicant No.	Disease or Ailment	Treatment Received	Dates Treated For	Present Status of Ailment	Full Name and Address of Attending Physician

Personal Physician _____ Medical Designation _____ Phone Number (____)_____

Address _____ City _____State _____ Zip Code _____

(Continue explanations at top of next page if necessary)

UAP-1 AR (7/10)

To enroll in the E-Z Way pre-authorized payment plan for renewal premiums, check the monthly or quarterly payment box, sign and date the authorization, and return with a voided personal check. Not available for initial premium.

Through the E-Z Way plan, your bank will pay your future **renewal** premiums from your checking account. The E-Z Way plan will eliminate the necessity of writing a check.

To take advantage of this convenient plan, simply complete the right-side portion of this form. On your next billing date, the premium will be paid by your bank. The payment will be reflected in your bank statement.

THE E-Z WAY PLAN AUTHORIZATION

TO RESERVE NATIONAL INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Reserve National Insurance Company, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

❒ **MONTHLY PAYMENT... or ❒ QUARTERLY PAYMENT**

_____ **x** _____

Date **Your signature EXACTLY as it appears on Bank Records**

(Explanations continued from previous page)

_____

_____

_____

_____

_____

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, **I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy related service organization, or other medical or medically related facility, insurance company or MIB, Inc. ("MIB"), that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114.**

I have paid to Reserve National Insurance Company the sum of $ _____ which is a ❒ Monthly ❒ Quarterly ❒ Semi-Annual ❒ Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. ❒ Date of application, applicable only on quarterly or longer modes. B. ❒ Date of issue C. ❒ Other _____

❒ SEND POLICY TO APPLICANT OR ❒ AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... **❒ Yes ❒ No**

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS A SCHEDULED BENEFIT POLICY WITH LIMITS FOR EACH COVERED EXPENSE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE THERE ARE LIMITATIONS ON THE AMOUNT OF BENEFITS PAYABLE FOR EACH COVERED EXPENSE.

Town and State where signed_____ this _____ day of _____ , _____

_____ _____

Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured/Applicant

The undersigned agent (a) represents Reserve National Insurance Company in connection with the insurance applied for; (b) will receive compensation from the Company if coverage is issued; and (c) may provide services to policyholders on behalf of the Company, subject to the Company's approval. The agent does not have authority to bind the Company.

I certifiy that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____

Signature of Agent

UAP-1 AR (7/10)

Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my: ❒ VISA ❒ MasterCard ❒ DISCOVER NOVUS

ACCOUNT# AS SHOWN ON CARD

				–				–				–			

EXPIRATION DATE_____

PLEASE SELECT

❒ Please charge my credit card for the initial premium.

Amount authorized $_____

❒ Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: ❒ Monthly Payment ❒ Quarterly Payment

AUTHORIZED SIGNATURE _____

(PLEASE SIGN HERE)

NAME OF CARDHOLDER _____

(PLEASE PRINT NAME AS SHOWN ON CARD)

DATE AUTHORIZED_____

Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114
www.ReserveNational.com

Applicant's Name Printed: _____

Policy Form Applied For: _____

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

* any of the services covered by the policy are also covered by Medicare.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

_____ _____

(Agent's Signature) (Applicant's Signature)

Reserve National Insurance Company
Home Office:
601 East Britton Rd.
Oklahoma City, Oklahoma 73114-7710

_____

(Date)

[For use when an applicant for Form DV-1 is eligible for Medicare]

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 06/29/2010	Rates	DV-1	New		DV-1 Rates AR.pdf

EXHIBIT I

Reserve National Insurance Company, NAIC# 68462

Policy Form DV-1

Attained Age Monthly Premium

Arkansas

$1000 Maximum

Attained Age	Regular Monthly	Bank Draft Monthly	Quarterly	Semi-Annual	Annual
0-18	$31.80	$29.25	$93.50	$185.10	$351.05
19-64	$31.80	$29.25	$93.50	$185.10	$351.05
65-99	$31.80	$29.25	$93.50	$185.10	$351.05

$1500 Maximum

Attained Age	Regular Monthly	Bank Draft Monthly	Quarterly	Semi-Annual	Annual
0-18	$39.75	$36.55	$116.85	$231.35	$438.85
19-64	$39.75	$36.55	$116.85	$231.35	$438.85
65-99	$39.75	$36.55	$116.85	$231.35	$438.85

Monthly Bank Draft = Monthly Rate x .92

Quarterly Rate = Monthly Rate x 2.94

Semi-Annual Rate = Monthly Rate x 5.82

Annual Rate = Monthly Rate x 11.04

SERFF Tracking Number:	*RNIC-126687030*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*46020*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*2010 Dental and Vision Policy*		
Project Name/Number:	*2010 Dental and Vision Policy/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/29/2010

Comments:

Attachment:

DV-1 Policy Readability Certificate.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/29/2010

Comments:

Form UAP-1 AR (7/10) is being submitted for approval and is attached to the Form Schedule.

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	06/29/2010

Comments:

Form OC DV-1 (7/10) is being submitted for approval and is attached to the Form Schedule.

		Item Status:	Status Date:
Satisfied - Item:	Form RP-A&H	Approved-Closed	06/29/2010

Comments:

This form was previously approved by your office.

Attachment:

RP-A&H.pdf

Reserve National
INSURANCE COMPANY
601 East Britton Road ▪ Oklahoma City, OK 73114
www.ReserveNational.com

READABILITY CERTIFICATION

FORM NUMBER: DV-1 – Supplemental Dental and Vision Expense Policy

The words, sentences, and syllables of Form **DV-1** were counted to be used in the Flesch Readability Formula in order to determine the readability score of the form. Formal names, medical terms and words defined (implicitly or explicitly) in the policy/rider/endorsement were not counted.

WORDS:	2,147
SENTENCES:	163
SYLLABLES:	2,666

This resulted in a Flesch Readability score of **88.392**.

Kyle Conrad

Digitally signed by Kyle Conrad
DN: CN = Kyle Conrad, C = US
Date: 2010.06.16 08:53:51 -05'00'

Kyle D. Conrad

_____

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel

Reserve National
INSURANCE COMPANY
5100 NORTHWEST GRAND BLVD. - OKLAHOMA CITY, OKLAHOMA 73118-1082

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or other information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For you own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might been payable under you present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of you present policy. This is not your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____
Date

_____
Applicant’s Signature